CASE NEW TO BLUE CROSS

TRANSITION ASSISTANCE PROGRAM

APPLICATION

Toll Free Number: 888-486-4227 - Fax: 805-480-7325

TA

Patient's Name: _____ **Date of Birth**: _____

Subscriber Name: _____

BCC Certificate/Identification number: _____

Patient/Guardian Phone Number(s): Home (___) _____ Work (___) _____

☐ **EMPLOYER NAME:** _____ **BCC Effective Date:** _____

Reason for requesting transition assistance (Please check and complete all sections that apply):

☐ **Pregnancy (Second or Third Trimester or High Risk)**

Expected Delivery Date: _____

OB Provider Name:_____Phone#_____

OB Hospital: _____

☐ **Under treatment for an acute condition or serious chronic condition. Please list each diagnosis/condition and treating provider:**

Diagnosis/Condition: _____

Provider Name: _____Phone #_____

Next appointment or procedure date: _____

Diagnosis/Condition: _____

Provider Name: _____Phone #_____

Next appointment or procedure date: _____

Diagnosis/Condition: _____

Provider Name: _____Phone #_____

Next appointment or procedure date: _____

Diagnosis/Condition: _____

Provider Name: _____Phone #_____

Next appointment or procedure date: _____

Other Comments: (Attach additional pages if needed)

_____

_____

Completed by: _____Direct Phone # _____